FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0005520

Facility Name: MOUNT ST. JOSEPH

Address: 24955 N. HWY 12 (Number) LAKE ZURICH,IL (City) 60047 (Zip Code)

County: LAKE

Telephone Number: 847-438-5050 **Fax #** 847-438-6313

IDPA ID Number: 36-2639774001

Date of Initial License for Current Owners: 1947

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: DON LASCO **Telephone Number:** 847-438-5050

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/01/02 to 6/30/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date) 10/03/03

(Type or Print Name) SISTER SHARON WILLIAMS

(Title) SUPERIOR

Paid Preparer

(Signed) (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number MOUNT ST. JOSEPH # 0005520 Report Period Beginning: 7/01/02 Ending: 6/30/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	132	Intermediate/DD	132	48,180	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	132	TOTALS	132	48,180	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	44,164	836		45,000	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,164	836		45,000	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.40%

D. How many bed-hold days during this year were paid by Public Aid?
2,069 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 1947

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 6/30/03 Fiscal Year: 6/30/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MOUNT ST. JOSEPH # 0005520 Report Period Beginning: 7/01/02 Ending: 6/30/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	143,182		22,528	165,710		165,710	(16,571)	149,139			1
2	Food Purchase		134,875		134,875		134,875	(13,488)	121,387			2
3	Housekeeping	231,612	7,765		239,377		239,377		239,377			3
4	Laundry	28,174	3,142		31,316		31,316		31,316			4
5	Heat and Other Utilities			191,284	191,284		191,284	(9,564)	181,720			5
6	Maintenance	120,418	45,755	258,019	424,192		424,192		424,192			6
7	Other (specify):* FARM	19,261	383	1,777	21,421		21,421	(21,421)				7
8	**TOTAL General Services**	542,647	191,920	473,608	1,208,175		1,208,175	(61,044)	1,147,131			8
	B. Health Care and Programs											
9	Medical Director	23,571			23,571		23,571		23,571			9
10	Nursing and Medical Records	2,119,152	55,114	22,802	2,197,068	(17,480)	2,179,588		2,179,588			10
10a	Therapy	206,721	4,500	8,741	219,962		219,962	(6,000)	213,962			10a
11	Activities											11
12	Social Services	83,609	3,525	2,978	90,112		90,112		90,112			12
13	Nurse Aide Training					17,480	17,480		17,480			13
14	Program Transportation											14
15	Other (specify):* DAY TRAINING	257,452	10,279	104,155	371,886		371,886	(371,886)				15
16	**TOTAL Health Care and Programs**	2,690,505	73,418	138,676	2,902,599		2,902,599	(377,886)	2,524,713			16
	C. General Administration											
17	Administrative	103,618	9,844	42,583	156,045		156,045		156,045			17
18	Directors Fees											18
19	Professional Services			70,170	70,170		70,170		70,170			19
20	Dues, Fees, Subscriptions & Promotions			14,905	14,905		14,905		14,905			20
21	Clerical & General Office Expenses	136,535	29,453		165,988	(5,538)	160,450		160,450			21
22	Employee Benefits & Payroll Taxes			976,712	976,712		976,712	(33,214)	943,498			22
23	Inservice Training & Education											23
24	Travel and Seminar			616	616		616		616			24
25	Other Admin. Staff Transportation			11,682	11,682		11,682		11,682			25
26	Insurance-Prop.Liab.Malpractice			62,593	62,593		62,593		62,593			26
27	Other (specify):*											27
28	**TOTAL General Administration**	240,153	39,297	1,179,261	1,458,711	(5,538)	1,453,173	(33,214)	1,419,959			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,473,305	304,635	1,791,545	5,569,485	(5,538)	5,563,947	(472,144)	5,091,803			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MOUNT ST. JOSEPH #0005520 Report Period Beginning: 7/01/02 Ending: 6/30/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			242,252	242,252		242,252	149,006	391,258			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			180,000	180,000		180,000	(219,600)	(39,600)			34
35	Rent-Equipment & Vehicles					5,538	5,538		5,538			35
36	Other (specify):*											36
37	**TOTAL Ownership**			422,252	422,252	5,538	427,790	(70,594)	357,196			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			2,699	2,699		2,699		2,699			41
42	Provider Participation Fee			315,652	315,652		315,652		315,652			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			318,351	318,351		318,351		318,351			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,473,305	304,635	2,532,148	6,310,088		6,310,088	(542,738)	5,767,350			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MOUNT ST. JOSEPH # 0005520 Report Period Beginning: 7/01/02 Ending: 6/30/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(30,059)	L1&2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(39,600)	L34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(506,552)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (576,211)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	31,139	VII L 14	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 31,139		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (545,072)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops	x		2,699	L 41	40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 2,699		47

STATE OF ILLINOIS

MOUNT ST. JOSEPH

ID# 0005520

Report Period Beginning: 7/01/02

Ending: 6/30/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4	NON-PATIENT MEALS	(30,059)	L1&2	4
5				5
6	RENTED FACILITY SPACE	(39,600)	L34	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14	DEPRECIATION	(64,467)	L30	14
15				15
16				16
17	PRIEST STIPEND	(6,000)	L10a	17
18				18
19				19
20				20
21				21
22				22
23	DAY TRAINING	(371,886)	L15	23
24	DAY TRAINING PAYROLL TAX	(26,579)	L22	24
25	FARM PAYROLL TAX	(6,635)	L22	25
26	FARM	(21,421)	L7	26
27				27
28	UTILITIES	(9,564)	L5	28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(576,211)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MOUNT ST. JOSEPH **#** 0005520 **Report Period Beginning:** 7/01/02 **Ending:** 6/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number MOUNT ST. JOSEPH **#** 0005520 **Report Period Beginning:** 7/01/02 **Ending:** 6/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	211,139	0	0	0	0	0	0	0	0	0	211,139	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(180,000)	0	0	0	0	0	0	0	0	0	(180,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	31,139	0	0	0	0	0	0	0	0	0	31,139	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	31,139	0	0	0	0	0	0	0	0	0	31,139	45

Facility Name & ID Number MOUNT ST. JOSEPH # 0005520 Report Period Beginning: 7/01/02 Ending: 6/30/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
DAUGHTERS OF ST. MARY OF PROVIDENCE	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		34	RENT	$ (180,000)	DAUGHTERS OF ST. MARY OF PROVIDENCE	100.00%	$	$ (180,000)	1
2	V		30	DEPRECIATION		DAUGHTERS OF ST. MARY OF PROVIDENCE	100.00%	213,473	211,139	2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ (180,000)			$ 213,473	$ * 31,139	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MOUNT ST. JOSEPH # 0005520 Report Period Beginning: 7/01/02 Ending: 6/30/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	SR. SHARON WILLIAMS	SUPERIOR	CEO TREASURER			84	100.00	SALARY	$ 58,618	L17 C1	1
2	SR. MARGARET SCHISSLE	ADMINISTRATOR	DIRECTOR/SEC			84	100.00	SALARY	45,000	L17 C1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 103,618		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MOUNT ST. JOSEPH # 0005520 Report Period Beginning: 7/01/02 Ending: 6/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization N/A
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MOUNT ST. JOSEPH # 0005520 Report Period Beginning: 7/01/02 Ending: 6/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3				N/A								3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number MOUNT ST. JOSEPH # 0005520 Report Period Beginning: 7/01/02 Ending: 6/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	#VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1998	8
	1999	9
	2000	10
	2001	11
	2002	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MOUNT ST. JOSEPH COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0005520

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number MOUNT ST. JOSEPH # 0005520 Report Period Beginning: 7/01/02 Ending: 6/30/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 147,565 B. General Construction Type: Exterior BRICK Frame BRICK Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

DEVELOPMENTAL TRAINING 1,010 SQUARE FEET

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	HOME & FARM	160 ACRES OR	1935	$ 8,000	1
2		6,969,600SQ.FT			2
3	TOTALS	#VALUE!		$ 8,000	3

Facility Name & ID Number MOUNT ST. JOSEPH # 0005520 Report Period Beginning: 7/01/02 Ending: 6/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	132			1969	$ 5,007,009	$ 146,096	30.5	$ 130,130	$ (15,966)	$ 5,007,009	4
5				1990	2,361,653	78,720	30	78,720		1,062,722	5
6				1990	68,729	2,290	30	2,290		30,915	6
7											7
8											8
	Improvement Type**										
9	LAND IMPROVEMENTS PRIOR YEARS			1993	29,005						9
10				1994	93,489						10
11				1995	44,713						11
12				1996	18,082						12
13				1997	42,570						13
14				1998	17,423						14
15				1999	21,853						15
16											16
17	PAVING DEC/2001				4,700	15,843		15,843		181,659	17
18											18
19	BUILDING IMPROVEMENTS-PRIOR YEARS			1991	74,205						19
20				1992	90,293						20
21				1993	180,181						21
22				1994	178,251						22
23				1995	231,228						23
24				1996	82,875						24
25				1997	71,814						25
26				1998	116,448						26
27				1999	121,823	120,417		120,417		807,354	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MOUNT ST. JOSEPH # 0005520 Report Period Beginning: 7/01/02 Ending: 6/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	BUILDING IMPROVEMENTS		$	$		$	$	$	37
38	AUTOMATIC TANK GAUGING SYSTEM	2-Jul	5,000						38
39	CARLSON HALL STEAM LINE	2-Jul	1,913						39
40	AUTOMATIC TANK GAUGING SYSTEM	2-Oct	8,167						40
41	CLEAN STEAM BOILERS	2-Nov	4,740						41
42	2 UNIT HEATERS IN GARAGE	2-Dec	6,145						42
43	HOT WATER HEATER ANGEL GUARDIAN	2-Dec	9,084						43
44	PENTAIR HEATERS POOL	2-Oct	5,481						44
45	THERAPY CENTER ROOF WORK	3-May	2,100						45
46	TWO REST ROOMS	3-Jan	32,000						46
47	REPLACE RADIANT IN BASEMENT	3-Feb	3,633						47
48	REPAIR SEWER IN CRAWL SPACE	3-Mar	4,714						48
49	ARCHITECTURAL SKETCH PLANS	3-Apr	2,640						49
50	FLOOR PANELS IN KITCHEN	3-May	12,830						50
51	SPEED CONTROL THERAPY	3-Jun	5,728						51
52	TRANSFER LIFT	3-Jun	6,448						52
53	AIR CONDITIONING ADMINISTRATION	3-Jun	124,900						53
54	AIR CONDITIONING WIRING	3-Jun	14,600						54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 9,106,467	$ 363,366		$ 347,400	$ (15,966)	$ 7,089,659	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MOUNT ST. JOSEPH # 0005520 Report Period Beginning: 7/01/02 Ending: 6/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 9,106,467	$ 363,366		$ 347,400	$ (15,966)	$ 7,089,659	1
2	BUILDING IMPROVEMENTS								2
3	NEW ROOF	Aug-99	1,800						3
4	BOILER REPAIRS	Aug-99	2,276						4
5	DRAIN TILE	Oct-99	2,500						5
6	EXTERIOR PAINT	Oct-99	5,234						6
7	NEW PUMP	Oct-99	2,117						7
8	CERAMIC TILE	Nov-99	1,743						8
9	HEAT EXCHANGER	Nov-99	3,608						9
10	BOILER SWITCH	Nov-99	2,736						10
11	CONDENSATE PUMP	Apr-00	4,325						11
12	FIRE DOOR	Apr-00	2,785						12
13	HOT WATER LINE	Apr-00	2,843						13
14	BOILER CONTROLS	Jun-00	5,048						14
15									15
16	EVAPORATOR COIL IN KITCHEN	Jul-00	2,400						16
17	BOILER GASKET	Aug-00	2,508						17
18	HEAT EXCHANGER	Aug-00	2,697						18
19	PLASTER SWINNING POOL	Nov-00	14,680						19
20	SERVICE COOLER COIL IN KITCHEN	1-Jan	3,900						20
21	PUMP IN ST. AL.S	1-Jan	2,094						21
22	SHOWER CABINET	1-Jan	5,550						22
23	DAY ROOM FURNITURE	1-Jan	9,573						23
24	WINDOW BLINDS	1-Mar	3,500						24
25	DOUBLE OVEN IN KITCHEN	1-Apr	7,950						25
26	POOL COMPRESSOR	1-Apr	13,600						26
27	WINDOW BLINDS	1-Apr	3,500						27
28	THERAPY ROOF CABLES	1-Jun	4,860						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,220,294	$ 363,366		$ 347,400	$ (15,966)	$ 7,089,659	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MOUNT ST. JOSEPH # 0005520 Report Period Beginning: 7/01/02 Ending: 6/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,220,294	$ 363,366		$ 347,400	$ (15,966)	$ 7,089,659	1
2	BUILDING IMPROVEMENTS								2
3	ROOF REPAIR	1-Jul	10,036						3
4	REPAIR SEWER LINE	1-Sep	23,771						4
5	REPAIR OF MUDRING TANK	1-Sep	2,170						5
6	A/C COMPRESSOR & CHILLER	1-Oct	12,700						6
7	DOOR REPLACEMENT	1-Oct	6,730						7
8	REPLACE SUBMERSIBLE WELL PUMP	1-Oct	11,995						8
9	PLUMBING WORK	1-Dec	27,162						9
10	SPEED CONTROL REPLACEMENT	2-Apr	3,722						10
11	PLUMBINF WORK	2-May	4,500						11
12	POOL LIGHTING	2-May	5,800						12
13	REPAIR DAMAGED DRY SYSTEM PIPE	2-Jun	3,500						13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,332,380	$ 363,366		$ 347,400	$ (15,966)	$ 7,089,659	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MOUNT ST. JOSEPH # 0005520 Report Period Beginning: 7/01/02 Ending: 6/30/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,173,525	$	$	$		$ 988,467	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,173,525	$ 39,190	$ 39,190	$		$ 1,027,657	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT TRANSPORT	2002 FORD VAN	2002	$ 23,334	$ 2,334	$ 2,334	$	10	$ 2,334	76
77										77
78										78
79										79
80	TOTALS			$ 23,334	$ 2,334	$ 2,334	$		$ 4,668	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,537,239	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 404,890	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 388,924	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (15,966)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 8,121,984	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	FARM EQUIPMENT	$ 40,316	$	$ 40,316	86
87	VEHICLES	457,050	27,159	347,494	87
88	NON-CARE	1,052,810	37,308	829,027	88
89					89
90					90
91	TOTALS	$ 1,550,176	$ 64,467	$ 1,216,837	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 5,538 Description: COPY MACHINES
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MOUNT ST. JOSEPH # 0005520 Report Period Beginning: 7/01/02 Ending: 6/30/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 80

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)	3,080	4,800		7,880
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)		9,600		9,600
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$ 3,080	$ 14,400	$	$ 17,480
10	SUM OF line 9, col. 1 and 2	(e)	$ 17,480			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	12
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	8
2. From other facilities (f)	
TOTAL TRAINED	20

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	9 C1	visits	23,571					23,571	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 23,571		$	$		$ 23,571	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number MOUNT ST. JOSEPH # 0005520 **Report Period Beginning:** 7/01/02 **Ending:** 6/30/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 843,141	$ 843,141	1
2	Cash-Patient Deposits	81,351	81,351	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	857,242	857,242	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	52,541	52,541	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	91,757	91,757	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,926,032	$ 1,926,032	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		8,000	13
14	Buildings, at Historical Cost		7,437,391	14
15	Leasehold Improvements, at Historical Cost	1,403,849	3,091,848	15
16	Equipment, at Historical Cost		2,747,035	16
17	Accumulated Depreciation (book methods)		(8,186,451)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,403,849	$ 5,097,823	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,329,881	$ 7,023,855	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 71,542	$ 71,542	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	81,351	81,351	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	699,828	699,828	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 852,721	$ 852,721	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 852,721	$ 852,721	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,477,160	$ 6,171,134	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,329,881	$ 7,023,855	48

***(See instructions.)**

Facility Name & ID Number MOUNT ST. JOSEPH # 0005520 Report Period Beginning: 7/01/02 Ending: 6/30/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,483,232	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,483,232	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(6,072)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (6,072)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,477,160	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MOUNT ST. JOSEPH # 0005520 Report Period Beginning: 7/01/02 Ending: 6/30/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,556,816	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,556,816	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,583	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	39,600	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 41,183	23
	D. Non-Operating Revenue		
24	Contributions	277,879	24
25	Interest and Other Investment Income***	14,261	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 292,140	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	DEVELOPMENTAL DAY TRAINING	413,877	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 413,877	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,304,016	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,208,175	31
32	Health Care	2,902,599	32
33	General Administration	1,453,173	33
	B. Capital Expense		
34	Ownership	427,790	34
	C. Ancillary Expense		
35	Special Cost Centers	2,699	35
36	Provider Participation Fee	315,652	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,310,088	40
41	**Income before Income Taxes (line 30 minus line 40)****	(6,072)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (6,072)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MOUNT ST. JOSEPH # 0005520 Report Period Beginning: 7/01/02 Ending: 6/30/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	29,151	29,346	406,437	13.85	3
4	Licensed Practical Nurses	4,670	4,865	61,933	12.73	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	10,003	10,198	112,181	11.00	9
10	Activity Assistants	12,000	12,152	94,540	7.78	10
11	Social Service Workers	5,395	5,593	83,609	14.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	6,657	6,772	64,195	9.48	14
15	Cook Helpers/Assistants	11,503	11,616	78,987	6.80	15
16	Dishwashers	20,462	20,762	257,452	12.40	16
17	Maintenance Workers	12,825	12,920	120,418	9.32	17
18	Housekeepers	27,512	27,972	231,612	8.28	18
19	Laundry	3,625	3,707	28,174	7.60	19
20	Administrator	4,000	4,043	58,618	14.50	20
21	Assistant Administrator	4,333	4,373	45,000	10.29	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,675	11,977	136,535	11.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	1,357	1,382	23,571	17.06	27
28	Qualified MR Prof. (QMRP)	11,076	11,196	129,200	11.54	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	79,878	81,678	1,486,543	18.20	30
31	Medical Records	2,476	2,521	35,039	13.90	31
32	Other Health Care(specify)					32
33	Other(specify) FARM	2,092	2,117	19,261	9.10	33
34	TOTAL (lines 1 - 33)	260,690	265,190	$ 3,473,305 *	$ 13.10	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	167	$ 9,185	L1 C3	35
36	Medical Director				36
37	Medical Records Consultant	103	4,128	L10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	74	3,897	L10a C3	40
41	Occupational Therapy Consultant	84	4,844	L10a C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	26	1,534	L10 C3	43
44	Activity Consultant	315	15,760	L10 C3	44
45	Social Service Consultant				45
46	Other(specify) PSYCHOLOGIST	30	1,478	L12 C3	46
47	PSYCHIATRIST	20	1,500	L12 C3	47
48	PODIATRIST	23	1,380	L10 C3	48
49	TOTAL (lines 35 - 48)	842	$ 43,706		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number MOUNT ST. JOSEPH # 0005520 Report Period Beginning: 7/01/02 Ending: 6/30/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SR. SHARON WILLIAMS	SUPERIOR		$ 58,618
SR. MARGARET SCHISSLER	ADMINISTRATOR		45,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 103,618

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
DELOITTE & TOUCHE	AUDITORS	$ 45,265
AUTOMATIC DATA PROCESSIN(	PAYROLL	18,238
CREMER KOPON	LEGAL	6,495
PIPER MARBURY	LEGAL	172
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 70,170

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 127,063
Unemployment Compensation Insurance	
FICA Taxes	680,905
Employee Health Insurance	62,356
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	106,388
TOTAL (agree to Schedule V, line 22, col.8)	$ 976,712

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	8,545
Health Care Worker Background Check	
(Indicate # of checks performed)	
LICENSE & FEES	3,995
DUES & SUBSCRIPTIONS	2,165
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,905

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	616
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 616

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MOUNT ST. JOSEPH # 0005520 Report Period Beginning: 7/01/02 Ending: 6/30/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5					N/A								
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number MOUNT ST. JOSEPH # 0005520 Report Period Beginning: 7/01/02 Ending: 6/30/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5 YEARS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 6,774 Line L 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 315,652
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? YES For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ N/A Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? YES If YES, please indicate the amount of income earned from such a program during this reporting period. $ 7,790
c. What percent of all travel expense relates to transportation of nurses and patients? 10
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? YES
Indicate the amount of income earned from providing such transportation during this reporting period. $ 0

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: DELOITTE & TOUCHE The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

MOUNT ST. JOSEPH 0005520 7/1/02-6/30/03

V. COST CENTER EXPENSES 2003 RECLASSIFICATION PAGE 3

FROM V. LINE 10		-17,480
TO V. LINE 13		17,480
RECLASSIFY NURSE AIDE TRAINING		

FROM V. LINE 21		-5,538
TO V. LINE 35		5,538
RECLASSIFY RENT_EQUIPMENT		

MOUNT ST. JOSEPH 0005520 7,1/02-6/30/03

V. COST CENTER EXPENSES/ OTHER PAGE 3

FARM	SALARIES	19,261
FARM	SUPPLIES	383
FARM	BENEFITS	1,777
FARM	P/R TAXES	6,635
	TOTAL	28,056

MOUNT ST. JOSEPH 0005520 7/1/02-6/30/03

V. COST CENTER EXPENSES/OTHER PAGE 3

DAY TRAINING	SALARY		257,452
DAY TRAINING	SUPPLIES		10,279
DAY TRAINING	BENEFITS	21,048	
	OCCUPANCY	25,880	
	TRANSPO	51,234	
	RENT	2,555	
	DEPREC	3,438	104,155
DAY TRAINING	PR/TAXES		26,579
	TOTAL		398,465

MOUNT ST. JOSEPH 0005520 7/1/02-6/30/02

V. COST CENTER EXPENSES PAGE 3

LINE 25 OTHER TRANSPORTTATION

FUEL	3,644
REPAIRS	7,216
LICENSE & FEES	822
TOTAL	11,682

MOUNT ST. JOSEPH 0005520 7/1/02-6/30/03

VI. ADJUSTMENT DETAIL PAGE 5

DIETARY	V. LINE 1 165,710 X .10 =(16,571)	
FOOD PURCHASE	V. LINE 2 134,875 X .10 =(13,488)	-30,059
UTILITIES	V. LINE 5	-9,564
FARM	V. LINE 7	-21,421
PRIEST STIPEND	V. LINE 10a	-6,000
DAY TRAINING	V. LINE 15	-371,886
DAY TRAINING	V. LINE 22 TAX (26,579)	
FARM	V. LINE 22 TAX (6,635)	-33,214
DEPRECIATION	V. LINE 30	-64,467
RENTED SPACE	V. LINE 34	-39,600
SUBTOTAL (A)		-576,211
RELATED PARTY COST		31,139
TOTAL ADJUSTMENTS		-545,072

MOUNT ST. JOSEPH 5520 7/1/02-6/30/03

VI. ADJUSTMENT DETAIL / UTILITIES SQUARE FOOTAGE PAGE 5

CARE RELATED AREA		
THERAPEUTIC CENTER		29,450
FRAME HOUSE		6,770
ADMINISTRATIVE BUILDING		6,890
NOVITIATE & ADMINISTRATION		11,120
ANGEL GUARDIAN		9,582
BOILER & LAUNDRY		4,690
CHAPEL		12,468
GARAGE		1,012
ST. MARY,S		11,691
JOSEPHS		9,464
PASSAGEWAY		5,392
ST. ALOYIOUS		9,270
GUANELLA		15,887
KITCHEN		5,749
GARAGE		660
CHAPLAIN,S HOUSE		4,022
ADMINISTRATIVE BUILDING 2ND FLOOR		3,445
	TOTAL	147,565
NON-CARE AREA		5,560
NOVITIATE & AUDITORIUM		1,768
	TOTAL	7,328
TOTAL SQUARE FOOTAGE		154,893
NON-CARE AREA 7,328 / 154,893	=	5
TOTAL UTILITIES LINE 5 PAGE 3		191,284
	X	5
TOTAL NON-CARE RELATED AREAS	=	9,564

MOUNT ST. JOSEPH 5520 PAGE 7
BOARD OF DIRECTORS

SR. PATRICIA MCCAFFERTY	PRESIDENT
SR. SHARON WILLIAMS	VICE PRESIDENT TREASURER
SR. RHONDA BROWN	SECRETARY / DIRECTOR
SR. RITA ROSE LEDING	DIRECTOR
SR. MARGARET SCHISSLER	DIRECTOR
SR. LOUISE WARNER	DIRECTOR

MOUNT ST. JOSEPH 5520 7/1/02-6/30/03

XVII. INCOME STATEMENT OTHER REVENUE PAGE 19

DEVELOPMENTAL TRAINING LINE 28a 413,877

MOUNT ST. JOSEPH 5520 7/1/02-6/30/03

XVIII. A. STAFFING AND SALARY COSTS PAGE 20

LINE 16 DAY TRAINING
LINE 31 PSYCHOLOGY

B. CONSULTANT

LINE 44 DENTIST